

Online Appendix. Medical document's

Sample Medical Document for Cannabis Authorization

**Medical Document Authorizing the use of Cannabis for
Medical Purposes under the Access to Cannabis for
Medical Purposes Regulations**

Health care practitioner's name and surname: _____

Profession: _____ License Number _____

Province of Licensure _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Patient's Given Name and Surname _____

Patient's Date of Birth (DD/MM/YYYY) _____

Daily quantity of dried cannabis to be used by the
patient: _____ g/day

The period of use is _____ day(s) _____ week(s) _____ month(s).

Health Care Practitioner's Signature: _____

Date Signed (DD/MM/YYYY): _____

Sample Medical Prescription

Prescriber's Name
License Number
Clinic Name
Address
Phone: xxx-xxx-xxxx Fax: xxx-xxx-xxxx

Name _____	DOB _____
Address _____	Date _____

*Drug Name, Drug Strength/Dosage Unit(s),
Dosage Form, Route, Frequency, Duration*

Quantity

Refills

Health Care Practitioner's Signature: _____